DEPARTMENT OF HEALTH			(	→ FORM	APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIÇATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
	155203	B. WING	· · · · · · · · · · · · · · · · · · ·		C <b>2/2011</b>
NAME OF PROVIDER OR SUPPLIER HILLCREST CENTRE FOR HE	EALTH AND REHABILITATION	20	EET ADDRESS, CITY, STATE, ZIP C 03 SPARKS AVENUE EFFERSONVILLE, IN 47130	ODE	·
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE
IN00084571.  Complaint IN00084 Federal/state defici	nvestigation of Complaint  4571 - Substantiated, iencies related to the d at F250, F272, F280 and  /11 and 1/12/11  00110 155203	F 000	Submission of this plan of does not constitute adm agreement by the provide of facts alleged or correction the statement of definition of the statement of definition of the statement of definition of the statement under st	ler of the truth ction set forth iciencies.  prepared of eand federal	
accordance with 4  Quality review 1/19 F 250 483.15(g)(1) PRON SS=D RELATED SOCIAL  The facility must preservices to attain of	LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HE also reflect state findings in 10 IAC 16.2.  2/11 by Suzanne Williams, RN VISION OF MEDICALLY SERVICE rovide medically-related social or maintain the highest	F 250	F250 Requires the facily provide medically-relate services to attain or main highest practicable physimental, and psychosocial being of each resident.  The facility will ensure to requirement is met throughout following:	d social ntain the ical, il well-	
ABURATORY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	Helm	inistrator	2/41	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2WN411

Facility ID: 000110

If continuation sheet Page 1 of 49

PRINTED: 01/20/2011

#### PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	*	155203	B. WING		01/12/2011
	PROVIDER OR SUPPLIER	EALTH AND REHABILITATION	203	ET ADDRESS, CITY, STATE, ZIP CODE S SPARKS AVENUE FFERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION
F 250	This REQUIREME by: Based on observarieview, the facility assisted staff to plabehaviors for a resirisk for elopement. affected 1 of 1 resismoking agreement for elopement (Residents.  Findings include:  A. During the Initia a.m. residents were onto the patio for a staff person was puthe building. During staff person identified herself at the top of the coole #3 was a hand-pring "12/29/10 per [name of Residents smoking session." on the patio smoking session." on the patio smoking the clinical record on 1/11/11 at 2:00	NT is not met as evidenced tion, interview and record failed to ensure social services an for management of ident who smoked and was at The deficient practice dent reviewed related to a nt and 1 of 5 residents at risk sident C) in a sample of 5  al Tour on 1/11/11 at 10:00 e observed exiting the facility is smoke break. A uniformed ulling a cooler on wheels out of g interview at this time, the ied herself as a dietary ee #3, and another staff person is a CNA, CNA #6. Taped to be pulled by Dietary Employee nted sign that indicated, ned of Director of Nursing] C] to have (1) cigg [sic] per All others only (2) ciggs per Resident C was not observed	F 250	<ol> <li>Resident C was not harmed.</li> <li>All residents who smo and have the risk of elopement have the potential to be affected.</li> <li>Resident Rights, Smol policy, Mood and Beh Program were reviewed with no changes made Attachments A, B, and Elopement Risk Assessment policy reviewed and updated include Elopement Bin (See Attachment D). staff were in-serviced Resident Rights, smok policy, mood and beha program, and Elopement Risk Assessment Procon 1-28-11.</li> <li>The Administrator or designee will utilize the Administrative Audit (See Attachment E) to ensure staff is aware on how to properly located interventions for resident interventions for resident.</li> </ol>	i.  king avior ad (See I C).  to nders All on king avior ent edure  Fool

included, but were not limited to, dementia,

	T-OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION		TE SURVEY MPLETED
<b></b>		155203	B. WIN				C 01/12/2011
	PROVIDER OR SUPPLIER	EALTH AND REHABILITATION		203 \$	ADDRESS, CITY, STATE, ZIP COPARKS AVENUE ERSONVILLE, IN 47130		77712711
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F 250	bipolar disorder, ar alcohol use.  The Social History dated 12/8/10, indicated 12/8/10, indicated involvement/Interespend their days? routines:smoke.  The Initial Social Sc 12/10/10 indicated included, but were questions re: smoked included, "A resided cigarettes he or show within the allotted smoking timout."  A Smoking Assess review date of 12/1 [repetitive] question Hx [history] of unsate Nurse's Note dated indicated, "Resider regardingsmoke in A Behavioral Contrasocial Worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to, related to the social worker date not limited to the social worker date not	and Psychosocial Assessment cated in the section for "Social sts/Hobbies, How did resident Describe past customary"  ervices Assessment dated the resident's mood indicators not limited to, "Repetitive ing times"  tled "Hillcrest Centre Resident dated 7-10-08" was included in it and was signed by the 0. "Safe Smoking," item #9 ent may smoke however many er are [sic] capable of smoking moking time (2, 3, etc.). If the garette at the end of the ne, the cigarette must be put ment dated 12/9/10 with 6/10 indicated, "Rep is r/t [related to] smoke time, fe smoking 12/15/10."  12/16/10 at 1:10 p.m. ent continues to badger staff oreaks."  act signed by the resident and d 12/16/10, included, but was	F 2	50	specific behaviors will be conducted week times 4 wee weekly times 4 we every 2 weeks tim months, then quartimes 2 quarters. I will be reviewed of facility's quarterly assurance meeting issues will be added and the above plan altered according!  5. The above plan of correction will be completed on or b February 11, 2011	5 days a ks, then eeks, then es 2 terly The audits during the quality and ressed in will be	

DEPART	TMENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
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F 250		•	F:	250			
	locations, per policy indicated, "I am will improve on them [b provide me with 1. 2. Solutions to resc Support, 5. Verbal as needed, 7. Res safety concerns."  A Social Service Pr (no time indicated) [Minimum Data Set is a tobacco user. information on quitt smoked for as long wishes to be honore [behavior] contract, monitor."  The record included "Problem: Non-Corpolicy," dated 12/16 indicated, "Complia [through] next reviewere not limited to, agreement w/[with] attorney] of 1 cigare needed]." Docume details of the reside brother to smoke or smoke break or a p smoke more cigare	Smoke at designated times & y/signed" The document ling to work with the staff to behaviors]. The staff will Problem solving techniques, olve these issues, 3. Praise, 4. reminders, 6. Reassurance ident teaching/education on logress Note dated 12/16/10 indicated, "Follow-up MDS of Jassessment] interview. Res. When asked if he would like ling res responded, No, I've as I can remember. Res's led. Res. placed on bx family aware. Will continue to dea Careplan Worksheet with mpliance with Smoking logo and 1/6/11. The goal lince with smoking policy thrum line with smoking logo and 1/6/11. The goal lince with smoking policy thrum line with smoking line with smokin					
		imum Data Set assessment cated in the section for					

Behavioral Symptoms: "Supporting Documentation:" "Res [resident] has become verbally aggressive with staff, unprovoked with

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 250 Continued From page 4 F 250 purpose r/t [related to] smoke breaks and smoking policy." The "Analysis of Findings" indicated, "Res. has become aggressive during smoke breaks...." "Care Plan Considerations" indicated, "Careplans will be developed per company policy to address physical and psychosocial well-being." Mood and Behavior Communication Memos indicated the following in the section titled. "Provide detailed information on the mood and/or behavior that the resident was experiencing:" 12/9/10 (time not indicated): "Resident continually asking when next smoke time is .... At times showing impatience with staff when wants not met immediately." 12/16/10 at 5:15 p.m., "I had taken residents out to smoke when 15 min. [minutes] had passed [name of Resident C] ask [sic] for a cig [cigarette], and when I told him no we had to go back in he told me he won't eat without a cig, and he was going to a cig [sic] from me if I didn't give him one." The possible trigger of the behavior indicated, "Wanted a cigarette." 12/16/10 at 8:00 p.m., "Resident went to shower room to use the B/R [bathroom] because was out of order - activity director walked by shower room & smelled smoke - res. already went back to his room across the hall. When confronted, he admitted to smoking in that shower room & gave me his cigarettes & lighter. Explained the importance of not smoking in the building &

vet."

observing smoke times, stated understanding." The possible trigger for the behavior indicated, "Wanted to go smoke but it wasn't smoke time

	OF DEFICIENCIES OF CORRECTION	1, ,	ER/SUPPLIER/CLIA CATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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F 250	Continued From pa	age 5		F	250			
	12/17/10 at 6:00 p. and he didn't want residents cigs, who smokes, and he composed the then got into mygoing to take the cigo get the nurse, wout she told him he set back down. To then I saw him take When nurse check the possible trigger "Wanting other cig." Wanting other cig. A psychiatric constinuicated, " Cont. break, cigs & mone of the possible trigger indicated the follow." Provide detailed in behavior that the result of the possible trigger that we didn't have cigarette. [Names back the cigarettes [sic] his cigarette of wouldn't put it out a repatly [sic] to him The possible trigger "Unknown."	m., "Took hhis smokes en I told him ouldn't have y face, and igs if he has when the number of the behalt wing in the second of the time to smooth of the behalt wing in the second of t	wanted other here was his the other residents. told me he was to. I had someone ree [name] came we them, he then fill get those cigs. If his pockets. Idn't find them." avior indicated, dated 12/20/10 fixated on smoking cation Memos ection titled, on the mood and/or experiencing: 6:05 AM I told uding Resident C) oke the third dents] gave me of Resident C] lite me he had and smoking and I kept smoking." avior indicated, er was received for					
	[treatment]."		h - h - d					
	The History and Ph	nysical at the	e behavior center,					

	FOF DEFICIENCIES DE CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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F 250	dated 12/31/10 ind Illness:More rec increasingly agitate behavioral problem money and he has [medication] seekir redirected. He also diet coke constant!  The resident was r 1/5/11.  Mood and Behavior indicated the follow "Provide detailed in behavior that the real/5/11 at 6:00 p.m. when they all got owas telling CNA he CNA told him he cand started yelling boss had a note or him, and told him s Resident wouldn't [sic]"  A Care Plan Works Behavior Care Plan 12/14/10 and 1/6/1 presents with primadepression, bipolar [alcohol] abuse, Oddisorder), and may following moods ar behaviors included questions - i.e. sme [symbol for with] sr "Episodes of mood	icated, "Hist ently, he has ed and has he has he been intrusing, and has community"  eadmitted to r Community ing in the set formation of esident was posted to smole an only have (I get 3 cigs on the smoke the had to do near what she had to do near what she he had to do near what she he had to do near what she had to do near what she he had to do no he had to do no he had so no he had no he	been seen to be been having been stealing we and med been difficult to be garettes and drinks the facility on the facility on the mood and/or experiencing: smokers at [sic] to of Resident C] to 3 cigs when 1. He got mad 1. He	F	250			

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DÉFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 250 Continued From page 7 F 250 review." Interventions included, but were not limited to, "Bx [behavior contract] in place." Documentation failed to indicate the plan had been updated with specific interventions to address the problems indicated during smoke breaks. During interview completed on 1/11/11 at 12:45 p.m., the facility's Nurse Consultant #1 indicated the resident eloped from the facility on 1/8/11. She indicated that during the investigation into the elopement, another resident told her Resident C said "he was going to [name of city across river in another state] to smoke what he wanted to smoke." The Nurse Consultant also indicated she was told by the facility's Admissions Coordinator that when she visited Resident C in the acute care hospital after the elopement, the resident indicated he was getting back at his brother related to the decrease in his cigarettes. During interview with the Social Worker and Social Services/Activities Consultant on 1/11/11 at 3:05 p.m., the Consultant indicated the resident had made a deal with his brother to smoke only one cigarette at each smoke break, and the facility had encouraged the resident to smoke just one cigarette. During interview completed 1/12/11 at 4:00 p.m. with Nurse Consultant #1 and the Social Worker. the Nurse Consultant indicated she thought the resident's brother and Power of Attorney wanted

the resident to smoke only one cigarette due to money issues. She indicated the staff would give the resident more cigarettes if he asked for them, since they were his, and staff wanted to collect money to buy him cigarettes. She also indicated the facility was concerned about infringing on the

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NAME OF PROVIDER OR SUPPLIER  HILLCREST CENTRE FOR HEALTH AND REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE  203 SPARKS AVENUE  JEFFERSONVILLE, IN 47130	
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resident's rights if he weren't allowed to smoke his cigarettes. The Social Worker indicated no specific interventions had been planned to assist the staff to deal with the one-cigarette agreement, and no family meeting or care planning had taken place related to the one-cigarette agreement.  B. An interview was completed on 1/11/11 at 12:45 p.m. with the facility's Nurse Consultant #1 and Nurse Consultant #2, the Administrator, and the Director of Nursing. During the interview, Nurse Consultant #1 provided a binder containing documentation related to the elopement of Resident C on 1/8/11.  An Elopement Risk Assessment dated 12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills?, Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, elusions, hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was marked with a checkmark: "Resident at risk for elopement, as evidenced by: dementia, depression, hy history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "Initiated." Interventions a elected for initiation	

	TMENT OF HEALTH	(	(				FORM	: 01/20/2011 APPROVED : 0938-0391
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F 250	Continued From pa	ge 9		F:	250			
	were: "1. Personal and stairwell alarms Check every [handw word] hour." The a nurse.	safety alar s, and 4. Fre vritten in bla	equent monitoring.	. ·	200			
	Admission Orders a 12/8/10, signed but included, but were r [Departure Alert Sysplacement q [every] "Above orders verific physician" with the espace]/10."	not dated b not limited to stem] rt. [rig   shift." The led per teler	y the physician, o, "Wanderguard ht] wrist - check nurse signed phone with					
	An Elopement Risk indicated a check rethe following question.	nark next to	"Yes" answers to e resident					a table of the control of the contro
	cognitively impaired skills?, Does the red dementia, OBS [org	sident have janic brain s	a diagnosis of syndrome]					
	Alzheimers, delusio depression, or schiz ambulate independe	zophrenia?, ently, with o	Does the resident or without the use					
	of an assistive device wander aimlessly?" wandering behavior	. Next to the a pattern o	e question, "Is the r routine tied to					
	resident's past?" wh was a checkmark. resident been recer	Next to the tly admitted	question, "Has the or readmitted					
	(within past 30 days situation?" where "l checkmark. On the	New admit" reverse sic	was written was a de of the					
	assessment in the s Assessment" was n "Resident at risk for	narked with	a checkmark:		*			

wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression, hx [history] of wandering aimlessly, ambulates

	OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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F 250	independently. New have been:" was a Interventions select Frequent monitoring hour. 5. Keep beha activities, 9. Music, risk, 14. Other: [har assessment was significant of the consultant of the consultant discussion to use the Wanderg on 12/8/10. The Sc Consultant indicate moved into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident went of bring into the facility and sathe resident needed a very requested it be used to be monitored for a control document the into the admission Ministricture.	otheckmark red for revieur Check ed for revieur Check ed for revieur Check ed for logs, 8. 13. Staff and written] Wagned by the me record far the reside 1/11/11 at Social Serviced how the guard system of that on the control of the reside that on the ity, she was aw from her ut to his broken was from her ut to his broken control of the resident of the control of th	next to "reviewed." w were: "4. very [handwritten] Recreational ware of wander /anderguard." The social worker.  illed to indicate the nt was completed.  3:05 p.m., the ices/Activities decision was made m for this resident es/Activities e day the resident office window that other's truck as the dent's belongings dicated she felt the rd at that time and the resident would e indicated she did  Set assessment esident did not have assessment ted a problem s been found to be of depression, ." The goal was, ility unattended	F	250			

	OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE S COMPL	
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F 250	out with my responding to work them [behaviors].  1. Problem solving resolve these issue Verbal reminders, Resident teaching/.  A Care Plan Works Behavior Care Plan 12/14/10 and 1/6/1 presents with primadepression, bipolar [alcohol] abuse, Odisorder), and may following moods at behaviors included	te elopement istraction and mpts to exit ly and proced vities of choiceds have be symptoms] of ices as need ed to indicate 12/8/10.  The tact signed be ed 12/16/10, ed to behavious to leave fact sible party. See" The downwith the staff will be techniques, es, 3. Praise, et ducation or sheet for "Proping indicated of a with "Problem indicated of the i	d re-orientation oldg [building]. dures. Encourage ce and interest. een met. Observe depression. ed or ordered." e the care plan  y the resident and included, but was ors, and," and "I have illty without signing 8. Not to enter ocument indicated, aff to improve on provide me with 2. Solutions to 4. Support, 5. ance as needed, 7. a safety concerns."  oblem: Mood and dates of 12/10/10, em: Resident of dementia, a [history] of ETOH we compulsive or all of the "The list of the limited to,"	F 25			
	"Wandering/Paci other's space." Th moods and behavi diffused daily thru l Interventions include	e Goal was " ors will be re through] nex	Episodes of directed and/or treview."		,		

	OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
			155203	B. WIN	1G _		1	C <b>2/2011</b>
	ROVIDER OR SUPPLIER	ALTH AND I	REHABILITATION		2	REET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE EFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	' MUST BE PRE	CEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	"Bx [behavior con	tract] in placement & find the flow Repression of the flow Repressio	cord for December behaviors nationals wandering truding into others' on 12/14,	F2	250			
	A psychiatric visit condicated, "Nsg [number having difficulty [symbol for not] slew lobby areas"  On 12/30/10 a physe "May send to behave the sent to behave the sent to be a sent to	sing] report mbol for with eping at noo sician's orde	s R [resident] n] adjustment - c [night] - staying in r was received for					·
	[treatment]."  The History and Ph dated 12/31/10 indi Illness:More receincreasingly agitate behavioral problem money and he has [medication] seekin redirected. He also diet coke constantly	cated, "Hist ently, he has d and has b s. He has b been intrusi g, and has l smokes ciç	ory of Present been seen to be een having been stealing we and med been difficult to be					
	The resident was re 1/5/11.	admitted to	the facility on					
	Documentation faile Risk Assessment w resident's return fro	as complete	ed upon the		 			
	Admission Orders a	and Plan of	Care for					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:		IULTIP LDING	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		1	55203	B. WI	1G		1	C <b>2/2011</b>
	ROVIDER OR SUPPLIER	ALTH AND REI	HABILITATION		20	EET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE EFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	Continued From pareadmission include "Treatments: Wand [checkmark] placer level: Amb [ambulation During interview on Director of Nursing need to check police Elopement Risk was from the behavior usame time, the Soc Services/Activities other and shook the monitoring of the re Elopement Risk As 12/10/10 were discontiled, "Specialized Doservation for Wase and Services of the dadministrator's office entitled, "Specialized Observation for Wase was indicated the dadministrator's office entitled, "Specialized Doservation for Wase was indicated the dadministrator's office entitled, "Specialized Observation for Wase was indicated the documents indicated hourly from 12/8/10/11:00 p.m. An unstancessary for 1 [system of the common of the continuous question of the continuous que	ded but were not lerguard to rt. valerguard to see if a rest required upon unit. During interview between the ads "No" esident indicate sessments dat ussed.  p.m., document #1 During interview between the adsumentation valerguard interview between the additional to read and under and the additional to read and under and the additional to the additional to read and under and the additional to read and under a read a r	wrist and "Activity  5 p.m., the ed she would assessment of on readmission erview at this d Social ked at each when the hourly ed on the ted 12/8 and  attation was related to the w at this time, was found in the nents were every Hour ents and The was monitored intil 12/13 at ated notation on cated, o longer checks d/t [due 1/12/11 at 3:45 d copy of "Unit ary" dated of Resident C] - g wellup for hourly C] [symbol for	F	250			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICATION		CATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
			155203	B. WII	۷G _			C <b>2/2011</b>
	ROVIDER OR SUPPLIER EST CENTRE FOR HE	EALTH AND	REHABILITATION		2	REET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE JEFFERSONVILLE, IN 47130		
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F 250	[discontinue] pleas indicate the Eloper care plan were upo made.	e." Docume nent Risk As lated when t	ssessment and he decision was	F	250			
	The Behavior Mont 2011 indicated on "Non-compliance [s smoking/smoking f 1/6/11 indicated on into other's rooms/ questions" on day s	1/5/11 one e symbol for w R/T Bx" on e e episode e offices" and	pisode of ith] vening shift. On ach of "Intruding					
	The record include at 3:00 p.m., which ambulating per self of distress noted."	indicated, "				,		
	Social services not with resident's brot behavior even after Brother stated resident. I don't know which behavior even after bright bri	her/POA about returning from the considering the considering the considering the considering to tall the considering to indicate to indicate the considering t	out res's continued om behavior unit.  r, I'll come talk to do with him. e locked down town] that would etting for resident. k to resident, and if g another facility."					
	During interview on Consultant #1 indic Social Worker to as for Elopement was resident was readm	ated she wa sk why an as not complet	s trying to find the ssessment of Risk ed when the					
	On 1/12/11 at 3:25	p.m., the fac	cility's Elopement					

	OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			155203	B. WING		C 01/12/2011
	ROVIDER OR SUPPLIER	ALTH AND I	REHABILITATION	2	REET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE BEFFERSONVILLE, IN 47130	
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F 272 SS=D	Risk Assessment F Social Worker. Re "Policy: Assess res To assure that all re all times. Procedur risk for elopement I risk assessment up with significant cha status. 2. Residen possible elopemen- interventions place During interview at indicated the policy This federal tag rela 3.1-34(a) 483.20, 483.20(b) (c)	Policy was poview of the policy was poview of the policy was poview of the policy completing admission admission admission admission admission at the was a social at the completing accurate, at a comprehending accurate, state. The assent of eart	policy indicated, otential elopement. If free from harm at tify residents at nog the elopement on, quarterly and ital/psychosocial dentified for iately have elopement" e Social Worker at services policy. Iplaint IN00084571.  ENSIVE  Iy and periodically andardized on resident's hensive eds, using the RAI sessment must information;	F 272	F272 Requires the facility must conduct initially and periodically comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility m make a comprehensive assessment of a resident's needs, using the Especified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision Mood and behavior patterns; Psychosocial well-being; Physic functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Sk conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	ust nt RAI d n; al

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE	R/SUPPLIER/CLIA CATION NUMBER:	' ' '	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
				A. BUILDIN B. WING	*		C
			155203	D. WING		01/1	2/2011
	ROVIDER OR SUPPLIER  ST CENTRE FOR HE  SUMMARY STA	ALTH AND F		2	REET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE IEFFERSONVILLE, IN 47130 PROVIDER'S PLAN OF CORRE	CTION	(VE)
PREFIX TAG	(EACH DEFICIENC) - REGULATORY OR L	Y MUST BE PRÊ	CEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 272	Continued From participation of the additional assessme Documentation of the	and procedul; summary informer protocols; carticipation  NT is not moview and intoresident was indicated in items of 5 resident was admother long to the resident cognaking skills gnosis of derome] Alzheiety, depressives the resident through the correction of the correction of the control of the correction of the corr	ormation regarding ormed through the and in assessment.  et as evidenced erview, the facility is assessed for a facility policy for idents. (Residents it dated 12/8/10 following initively impaired it dated 12/8/10 following it dated 12/8/1	F 272	The facility will ensure this requirement is met through the following:  1. Resident B and C were harmed. 2. All residents have the potential to be affected 3. Elopement Risk Assessment policy reviewed and updated include Elopement Bin (See Attachment D). A staff Elopement Risk Assessment Procedure 1-28-11.  4. The Administrator or designee will utilize the Administrative Audit 1 (See Attachment E) to ensure Elopement Risk Assessments are being completed appropriated Audits will be conduct days a week times 4 we then weekly times 4 we then every 2 weeks time months, then quarterly times 2 quarters. The a will be reviewed during	ders all on col y ed 5 eeks, eeks, es 2	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C 01/12/2011

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			155203	B, WI	√G_		1	C 2/2011
	PROVIDER OR SUPPLIER	ALTH AND	REHABILITATION		20	REET ADDRESS, CITY, STATE, ZIP CODE 103 SPARKS AVENUE EFFERSONVILLE, IN 47130		
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F 272	wandering behavior resident's past? wa the question, "Has t admitted or readmit	r a pattern of s written: "the resident the resident ted (within e situation?' erse side of nmary of Askmark: "Refered by: d ory] of wan dently. Next entions self safety alar s, and 4. Frowritten in blassessment Assessment Assessment with poor of sident have ganic brain: "Is the law the pattern of sident have ganic brain: "Is the law the pattern of sident have ganic brain: "Is the law the pattern of sident have ganic brain: "Is the law the law the law the law admitted of and not a New admitted of and not a New admitted section for "everse side section for "estated not a section for	Possibly." Next to been recently past 30 days) and was written: "New the assessment in sessment" was esident at risk for ementia, dering aimlessly, to "Appropriate a checkmark next ected for initiation m devices, 2. Exit equent monitoring. ank space was the was signed by a not dated 12/10/10 o "Yes" answers to e resident decision making a diagnosis of syndrome] ations, anxiety, Does the resident requestion, "Is the routine tied to bly" was written question, "Has the or readmitted ccepting of the was written was a de of the Summary of	F	272	facility's quarterly quality assurance meeting and issues will be addressed and the above plan will altered accordingly.  5. The above plan of correction will be completed on or before February 11, 2011.		

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 272 Continued From page 18 F 272 "Resident at risk for elopement, as evidenced by: wanders/pacing, [arrow pointing down] cognition, ambulates independently." dementia, depression. hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour. 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker. On 1/12/11 at 2:55 p.m., documentation was provided by Nurse Consultant #1 related to the hourly monitoring. During interview at this time. she indicated the documentation was found in the Administrator's office. The documents were entitled, "Specialized Monitoring Every Hour Observation for Wandering Residents and Sexually Inappropriate Residents" The documents indicated Resident C was monitored hourly from 12/8/10 at 5:00 p.m. until 12/13 at 11:00 p.m. An unsigned and undated notation on the document dated 12/13/10 indicated, "Interdisciplinary team deemed no longer necessary for 1 [symbol for hour] checks d/t [due to] no exit leaving behavior." On 1/12/11 at 3:45

[discontinue] please."

p.m. Nurse Consultant #1 provided copy of "Unit Manager Morning Meeting Summary" dated 12/13/10 which indicated, "[name of Resident C] continuous questions, not sleeping well...up for IDT [interdisciplinary team] review hourly [checkmark]s, [name of Resident C] [symbol for no] attempts @ departure elopement d/c

Documentation failed to indicate the Elopement Risk Assessment and plan were updated when

		R/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	•		155203	B. WI	NG		i	C 2/2011
	ROVIDER OR SUPPLIER	ALTH AND I	REHABILITATION		2	REET ADDRESS, CITY, STATE, ZIP CODE 103 SPARKS AVENUE LEFFERSONVILLE, IN 47130		
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F 272	the decision was m discontinue the hour on 12/30/10 a phys "May send to behave [treatment]."  The History and Ph dated 12/31/10 individuals: More receincreasingly agitate behavioral problem money and he has [medication] seeking redirected. He also diet coke constantly. The resident was realized to the resident was realized to the resident was resident's return from During interview comp.m., the facility's Norther resident eloped. During interview on Consultant #1 indicates of the resident was readmed to 1/12/11 at 3:25 Risk Assessment Procial Worker. Revent Policy: Assess resident:	ade on 12/1 rly monitori ician's orde vioral unit fo  ysical at the cated, "Hist ently, he has d and has b s. He has b been intrusi g, and has smokes cic ""  radmitted to ed to indicat as complete m the beha mpleted on urse Consu from the fact ated she wa k why an as not complete itted to the com, the fact olicy was pr view of the p idents for p	r was received for r evaluation & tx  behavior center, ory of Present been seen to be seen having been stealing we and med been difficult to be garettes and drinks  the facility on  e an Elopement ed upon the vior center.  1/11/11 at 12:45 Itant #1 indicated cility on 1/8/11.  3:15 p.m., Nurse is trying to find the esessment of risk ed when the facility on 1/5/11.  cility's Elopement ovided by the policy indicated, otential elopement.	F2	272			
	To assure that all re	sidents are	free from harm at		ĺ		!	

	TMENT OF HEALTH		1				FORM	01/20/2011 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE	R/SUPPLIER/CLIA CATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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	PROVIDER OR SUPPLIER EST CENTRE FOR HE	ALTH AND I	REHABILITATION		2	REET ADDRESS, CITY, STATE, ZIP CODE 103 SPARKS AVENUE IEFFERSONVILLE, IN 47130		
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F 272	Continued From parall times. Procedur risk for elopement to risk assessment up with significant chart status. 2. Residen possible elopement interventions placed 2. The clinical recoreviewed on 1/12/1 indicated the resided An Elopement Risk indicated "Yes" to the resident cognitively making skills? Doe diagnosis of demens yndrome], Alzheim anxiety, depression the resident have an communication prolivere answered "No Assessment" indicated elopement at this tirdementia/HOH [harby a nurse.  An Elopement Risk indicated "Yes" to the resident cognitively making skills? Doe diagnosis of demens yndrome] Alzheime anxiety, depression resident have any hommunication prolipeen recently admit 30 days) and not acother questions were	es: 1. Ider by completir on admission admission admission ages in mer ts who are it will immed at to prevent at 2:55 p. In the admission and a seessment following impaired with a sthe resident and "Did of hearing and "Did of hearing" and "Did of hearing and "Did of hearing and "Did of hearing and "Did of hearing" and "Did of hearing and "Did of hearing" and "Did of hearing" and "Did of hearing and "Did of hearing" and "Did of hearing" and "Did of hearing" and "Did of hearing and "Did of hearing" and "Did of heari	ng the elopement on, quarterly and ital/psychosocial dentified for iately have elopement"  Jent B was m. The record itted on 12/22/10.  Int dated 12/23/10 questions: "Is the ith poor decision ent have a ganic brain ons, hallucinations, hrenia?, and Does vision, or other questions mary of ent is not at risk for agnosis: "I" and was signed it dated 1/8/11, questions: "Is the ith poor decision in have a ganic brain ins, hallucinations, hrenia?, Does the on, or decision in the formal in	F	272			

PRINTED: 01/20/2011

#### PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 272 Continued From page 21 F 272 F280 Resident has the right, "Summary of Assessment" indicated, "Resident is unless adjudged incompetent or at risk for elopement, as evidenced by: new otherwise found to be incapacitated environment, dementia" "Appropriate interventions have been:" was checkmarked for under the laws of the State, to "Reviewed." Also checkmarked was "Plan of participate in planning care and Care updated." The intervention was: "14. treatment or changes in care and Wanderquard." treatment. A comprehensive care The Medication Administration Record for plan must be developed within 7 December 2010 indicated the resident had a days after the completion of the Wanderguard to the left wrist which was checked each shift for placement and function on 12/23/10

During interview on 1/12/11 at 4:00 p.m., the Social Worker indicated Resident B was not deemed an elopement risk upon assessment, but the family requested she have a Wanderguard placed, due to a history of wandering, and a physician's order was obtained and care was planned related to the history of wandering at that time. The Social Worker indicated she had not completed another Elopement Risk Assessment at that time but should have.

This federal tag relates to Complaint IN00084571.

∫ 3.1-31(a)

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP

and all dates afterwards.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the

F280 Resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident is legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

The facility will ensure this requirement is met through the following:

1. Resident C was not harmed.

F 280

#### PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 22 F 280 2. All residents have the comprehensive assessment; prepared by an potential to be affected. interdisciplinary team, that includes the attending 3. Care Plan Development physician, a registered nurse with responsibility for the resident, and other appropriate staff in and Review Procedure disciplines as determined by the resident's needs. reviewed with no changes and, to the extent practicable, the participation of made (See Attachments F). the resident, the resident's family or the resident's Interdepartmental Team inlegal representative; and periodically reviewed and revised by a team of qualified persons after serviced on the above each assessment. policy on 1-28-11. 4. The Administrator or designee will utilize the Administrative Audit Tool This REQUIREMENT is not met as evidenced

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to ensure care plans related to smoking and elopement risk were revised with new interventions as the resident's needs changed. The deficient practice affected 1 of 1 resident reviewed related to a smoking agreement and 1 of 5 residents reviewed related to elopement risk in a sample of 5. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted on 12/8/10. Diagnoses included, but were not limited to, dementia, depression, obsessive compulsive disorder, bipolar disorder, and history of tobacco and alcohol use.

1A. The Social History and Psychosocial Assessment dated 12/8/10, indicated in the section for "Social Involvement/Interests/Hobbies, How did resident spend their days? Describe

- 4. The Administrator or designee will utilize the Administrative Audit Tool (See Attachment E) 5 days a week times 4 weeks, then weekly times 4 weeks, then every 2 weeks times 2 months, then quarterly times 2 quarters The audits will be reviewed during the facility's quarterly quality assurance meeting and issues will be addressed and the above plan will be altered accordingly.
- 5. The above plan of correction will be completed on or before February 11, 2011.

	FOF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
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F 280	Continued From parpast customary rou The Initial Social Set 12/10/10 indicated included, but were questions re: smok The facility policy tity Smoking Policy Upthe resident's recorresident on 12/10/1 indicated, "A reside cigarettes he or she within the allotted sresident has a lit cigallotted smoking tin out."  A Smoking Assessive was a sessive was date of 12/10 [repetitive] question Hx [history] of unsated indicated, "Reside regardingsmoke the A Behavioral Contrassocial Worker date not limited to, relate "Non-compliance whave agreed to 1. Social Worker date not limited to, relate "Non-compliance whave agreed to 1. Social Worker date not limited to, relate "Non-compliance whave agreed to 1. Social Worker date not limited to, relate "Non-compliance whave agreed to 1. Social was needed, "I am will improve on them [b provide me with 1. 2. Solutions to resonance where the provi	tines:smoother resident the resident not limited the fing times	essment dated t's mood indicators o, "Repetitive "  st Centre Resident 08" was included in signed by the moking," item #9 oke however many apable of smoking e (2, 3, etc.). If the e end of the rette must be put  12/9/10 with ed, "Rep d to] smoke time, 12/15/10."  t 1:10 p.m. es to badger staff  by the resident and included, but was ors, policy," and "I esignated times & The document with the staff to The staff will oliving techniques, ssues, 3. Praise, 4. 6. Reassurance	F 28			

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 Continued From page 24 F 280 safety concerns." A Social Service Progress Note dated 12/16/10 (no time indicated) indicated, "Follow-up MDS [Minimum Data Set] [assessment] interview. Res. is a tobacco user. When asked if he would like information on quitting res responded. No. I've smoked for as long as I can remember. Res's wishes to be honored. Res. placed on bx [behavior] contract, family aware. Will continue to monitor." The record included a Careplan Worksheet with "Problem: Non-Compliance with Smoking Policy," dated 12/16/10 and 1/6/11. The goal indicated, "Compliance with smoking policy thru [through] next review." Interventions included, but were not limited to. "Remind res [resident] of agreement w/[with] brother/POA [power of attorney] of 1 cigarette per break prn [as needed]." Documentation failed to indicate details of the resident's agreement with the brother to smoke only one cigarette at each smoke break or a plan if the resident wished to smoke more cigarettes. The admission Minimum Data Set assessment dated 12/16/10 indicated in the section for Behavioral Symptoms: "Supporting Documentation:" "Res [resident] has become verbally aggressive with staff, unprovoked with purpose r/t [related to] smoke breaks and smoking policy." The "Analysis of Findings"

psychosocial well-being."

indicated, "Res. has become aggressive during smoke breaks...." "Care Plan Considerations" indicated, "Careplans will be developed per company policy to address physical and

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12/17/10 at 6:00 p.m., "Took him out to smoke, and he didn't want his smokes, wanted other residents cigs, when I told him here was his smokes, and he couldn't have the other residents. He then got into my face, and told me he was going to take the cigs if he has to. I had someone go get the nurse, when the nurse [name] came

vet."

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diet coke constantly...."

The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ...More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks

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breaks.

been updated with specific interventions to address the problems indicated during smoke

During interview completed on 1/11/11 at 12:45

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resident's rights if he weren't allowed to smoke his cigarettes. The Social Worker indicated no specific interventions had been planned to assist the staff to deal with the one-cigarette agreement, and no family meeting or care planning had taken place related to the one-cigarette agreement.

1B. An Elopement Risk Assessment dated

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thru [through] the next review." Interventions included, "Complete elopement risk assessment. Use Redirection, distraction and re-orientation when resident attempts to exit bldg [building]. Follow facility policy and procedures. Encourage

			ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 280	participation in act Ensure all basic n for s/s [signs and Mental health served by the	ivities of choceds have be symptoms] or ices as need led to indica 12/8/10.  and Plan of it not dated led to indica 12/8/10.  and Plan of it not limited by stem] rt. [rigy] shift." The idea of the writter of the writ	een met. Observe of depression. ded or ordered." te the care plan  Care dated by the physician, c, "Wanderguard ght] wrist - check on urse signed phone with of is as: "12/[blank  ant dated 12/10/10 of "Yes" answers to e resident decision making a diagnosis of syndrome] nations, anxiety, Does the resident or without the use dor routine tied to ibly" was written question, "Has the d or readmitted occepting of the was written was a de of the 'Summary of	F 280			

			ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280	hx [history] of wand independently. Ne have been:" was a Interventions select Frequent monitorin hour. 5. Keep beha activities, 9. Music, risk, 14. Other: [ha assessment was sessment was	dering aimle at to "Approcheckmark ted for revieg. Check envior logs, 8. 13. Staff andwritten] Wagned by the analysis of the color of t	priate interventions next to "reviewed." were: "4. very [handwritten] Recreational ware of wander /anderguard." The social worker.  3:05 p.m., the ices/Activities decision was made m for this resident es/Activities e day the resident the Administrator office window that other's truck as the dent's belongings dicated she felt the rd at that time and the resident would e indicated she did mentation was #1 related to the view at this time, on was found in the cuments were g Every Hour sidents and ats" The C was monitored in until 12/13 at indated notation on ndicated,	F	280			

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F 280	continuous questio IDT [interdisciplinal [checkmark]s, [nan no] attempts @ de [discontinue] pleas indicate the Elopen care plan were upomade.  The admission Min dated 12/16/10 indivandering behavio period.	mbol for ho behavior." ( tant #1 providenting Surficated, "[nations, not sleetly team] revide of Residual ture elope." Document Risk A lated when imum Data cated the residuring the second of the	on 1/12/11 at 3:45 ided copy of "Unit mary" dated me of Resident C] - ping wellup for iew hourly ent C] [symbol for ement d/c entation failed to ssessment and the decision was  Set assessment esident did not have e assessment	F	280			
	out with my respon	ed 12/16/10, ed to behave ve/Elopemento leave facts sible party.  e" The context with the staff with the staff with techniques education of the staff of "Prindicated and with "Probary diagnosidisorder, he	included, but was iors, ent," and "I have sility without signing 3. Not to enter focument indicated, aff to improve on Il provide me with 2. Solutions to 4. Support, 5. ance as needed, 7. In safety concerns."  oblem: Mood and dates of 12/10/10, lem: Resident s of dementia, x [history] of ETOH					

	T OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) M		PLE CONSTRUCTION 3	(X3) DATE SU COMPLE	
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F 280	disorder), and may following moods ar behaviors included "Wandering/Paci other's space." The moods and behavior diffused daily thru [Interventions include "Bx [behavior corbracelet - check plashift."  The Behavior Mont 2010 indicated the including, but not lift on day shift on 12/rooms and offices 12/18/10, 12/25/10  A psychiatric visit of indicated, "Nsg [nuthaving difficulty [sy [symbol for not] sle lobby areas"  On 12/30/10 a phys "May send to behat [treatment]."  The History and Physical dated 12/31/10 ind Illness:More recoincreasingly agitate behavioral problem money and he has [medication] seekir	exhibit any exhibit any exhibit any exhibit any exhibit any exhibit any exhibit and exhibi	s." The list of at limited to, cilityIntruding into l'Episodes of edirected and/or ext review." e not limited to, ce. Wanderguard unctioning q [every] cord for December d behaviors ntinuous wandering truding into others' on 12/14, 10. dated 12/20/10 ts R [resident] h] adjustment - ce [night] - staying in the evaluation & tx	F	280			

#### PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 34 F 280 The resident was readmitted to the facility on 1/5/11. Documentation failed to indicate an Elopement

The Behavior Monthly Flow Record for January 2011 indicated on 1/5/11 one episode of "Non-compliance [symbol for with] smoking/smoking R/T Bx" on evening shift. On 1/6/11 indicated one episode each of "Intruding into other's rooms/offices" and "Rep [repetitive] questions" on day shift.

Risk Assessment was completed upon the resident's return from the behavior center.

Admission Orders and Plan of Care for readmission included, but were not limited to,

"Treatments: Wanderguard to rt. wrist [checkmark] placement q shift" and "Activity

level: Amb [ambulatory].

The record included no nurse's notes after 1/6/11 at 3:00 p.m. The notes for 1/6/11 at 3:00 p.m. indicated, "...Resident up ambulating per self...No s/s [signs and symptoms] of distress noted."

Social services notes for 1/6/11 indicated, "Spoke with resident's brother/POA about res's continued behavior even after returning from behavior unit. Brother stated res knows better, I'll come talk to him. I don't know what else to do with him. Discussed options including the locked down men's unit in [name of another town] that would possibly be more appropriate setting for resident. Brother stated he wanted to talk to resident, and see if he could get behaviors under control, and if not he would pursue considering another facility." Documentation failed to indicate care plans were updated at this time.

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And the second s	The state of the s		155203	B. WIN			01/12	C 2/2011
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F 323 SS=G	HAZARDS/SUPER The facility must en environment remail as is possible; and adequate supervisit prevent accidents.	1/12/11 at ated she wask why an as not complet nitted to the p.m., the far colley was possidents for pesidents for pesidents are to completing the state of the period of the period at	as trying to find the assessment of Risk and when the facility on 1/5/11.  cility's Elopement rovided by the colicy indicated, otential elopement. If the free from harm at a tify residents at any the elopement on, quarterly and otal/psychosocial dentified for fately have elopement"  To VICES  To VICES  To resident for accident hazards and receives stance devices to		280	F323 Requires the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  The facility will ensure this requirement is met through the following:  1. Resident C was hospitalized. All door alarms were checked for functionality. Keypads, Maglocks, and Exit Stoppers were ordered to replace the "Radio Shac alarms in facility on 1-10 11 and 1-11-11. Items were delivered on 1-12-and installation process initiated.  2. All residents have the potential to be affected. Maintenance or designed will check all alarms daily account of the control	o k" 0- 11	
	This REQUIREMENT by:	NT is not m	et as evidenced ·			•	· · · · · · · · · · · · · · · · · · ·	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ALTH AND	REHABILITATION	20	EET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE EFFERSONVILLE, IN 47130		
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F 323	A. Based on record facility failed to enselopement was assisted the resident was suffer 1 of 5 residents elopement in a sam Resident C eloped non-responsive on adjoining city across required emergenchospitalized with dilimited to, alcohol in required ventilators.  B. Based on obserinterview, the facility used to alert staff to without supervision deficient practice has 16 residents identified perment.  Findings include:  A. An interview was 12:45 p.m. with the and Nurse Consultation of Nurse Consultat	d review and ure a reside the sessed, care appervised to reviewed reple of 5. (Form the fact public trans is a river. They medical seagnoses incontext and the potential of the	nt at risk for was planned, and prevent elopement lated to risk for Resident C) cility and was found portation in an he resident ervices and was luding, but not The resident ng hospitalization.  rd review, and nsure door alarms exiting the facility oning. The ntial to affect 16 of acility at risk for  d on 1/11/11 at trse Consultant #1 Administrator, and the interview, a binder containing lopement of  sted on 1/8/11, facility's 6:00 a.m. n., Resident C medications.	F 323	3. Elopement Risk Assessment Procedure Care Plan Developmer and Review Procedure reviewed and the Elopement Risk Assessment Procedure updated (See Attachme and F). Daily Checklii Wanderguards and Oth Alarms reviewed and updated (See Attachme G). All staff in-service the Elopement Risk Assessment Procedure the Interdisciplinary T in-serviced on the Care Plan Development and Review Procedure, Maintenance and Nurs Management staff in- serviced on Daily Che for Wanderguards and Other Alarms on 1-28- 4. The Administrator or designee will complete Administrative Audit 7 5 days a week times 4 weeks, then weekly tin	ent D st for ner ent ed on and eam e l se cklist -11.	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TOF DEFICIENCIES OF CORRECTION		/IDER/SUPPLIER/CLIA (X2) W FIFICATION NUMBER: A. BUI			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER HILLCREST CENTRE FOR HEALTH AND		REHABILITATION		2	REET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE DEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PR	ECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Also included in the containing a Wandowristband cut, and interview, Nurse Coitems were found ir room during investi indicated the reside wristband with the rindicated it was unlused to leave the fat Written statements after the elopement RN #4, "On the nigminute checks on [given his a.m. [mor around 6:00 a.m., a Wanderguard on h [medications] he dinhere."  LPN #5, "I went to and attempted to gordered. He wasn's smokers lounge an [symbol for with] we know his breakfast touched it. I was a wasn't anywhere so events unfolded he and left the facility.  During telephone ir at 10:45 p.m., RN resident every 15 n-1/8/11) since he his center. She indications in the content of t	binder was erguard brasses a nail of a nail of a nail of a nail of a nail clippers and at the first wist. We have the first was	celet with the clipper. During the indicated the nt's drawer in his the elopement. She arently cut the She also h door the resident duty before and the following:  I performed 15 esident C]He was [medications] at ime I noted a hile taking his meds he did not 'like it  O 10 AM [a.m.] medication as I went to the there. I spoke pervisor and let her here and he hadn't blocate him and he had looked. As the safety band off  repleted on 1/11/11 d she checked the the night of 1/7/11 to the behavior	F	323	weeks, then every 2 weeks times 2 months, then quarterly times 2 quarter (See Attachment E). The audits will be reviewed during the facility's quarterly quality assurated meeting and issues will addressed and the above plan will be altered accordingly.  5. The above plan of correction will be completed on or before February 11, 2011.	nce be	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA ICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	
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	PROVIDER OR SUPPLIER	ALTH AND	REHABILITATION	•	20	EET ADDRESS, CITY, STATE, ZIP CODE 03 SPARKS AVENUE EFFERSONVILLE, IN 47130		
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F 323	indicated she had released that Resident residents. She indicuntil about 2:30 a.m the door to the smoremainder of the nithe resident about a smoke and then resident about a smoke and then resident was initiated on 1/8/11 (and the resident was room nurse on 1/8/information on the report indicated, "C Arrived to find [age transportation complystanders stated to drinking and sudde Pupils dilated and rindicated further as intravenous line was administered, and to oxygen at 15 liters and transported to the Hospital records in resident was transferoom to a hospital in the sident was transferoo	a problem vertices and then exact the resident to indicate the panyl bus what pt [patient to panyl bus what pt [patient to panyl became to panyl became to panyl became to predict the binder the hospitate the binder erred from the panyl and indicated, the was not to the panyl and the pany	d money from other sident had slept was up sitting at or in the lounge the dicated she saw fter he went out to s room.  Ite the every 15 dent was seen a.m. on 1/8/11.  ecords in the of the resident was ible time 9:39 a.m.), by the emergency a.m. Narrative medical services for unresponsive. of local public mresponsive. ent] had been a unresponsive.  In the resident, an larcan was was started on by rebreather mask emergency room.  Indicated the the emergency are unit on 1/11/11 physical note dated "in the ER asally	F	323			

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 39 F 323 remained nonresponsive more than 3 hours after intubation, so we called for vent [ventilator] management." The assessment and plan indicated, "...Will admit and treat....CNS [central nervous system]: alcohol intoxication; no sedation. CPAP (continuous positive airway pressure) trial when he wakes up, followed by spontaneous breathing trial with weaning parameters. Expect will be able to extubate him tonight or tomorrow morning...!" The clinical record for Resident C was provided and reviewed on 1/11/11 at 2:00 p.m. The record indicated the resident was admitted to the facility on 12/8/10 from another long term care facility. An Elopement Risk Assessment dated 12/8/10 indicated "Yes" answers to the following questions: "Is the resident cognitively impaired with poor decision making skills? Does the resident have a diagnosis of dementia, OBS [organic brain syndrome] Alzheimers, delusions. hallucinations, anxiety, depression, or schizophrenia?, Does the resident ambulate independently, with or without the use of an assistive device?", and "Does the resident wander aimlessly?". Next to the question, "Is the wandering behavior a pattern or routine tied to resident's past? was written: "Possibly." Next to the question, "Has the resident been recently admitted or readmitted (within past 30 days) and not accepting of the situation?" was written: "New admit." On the reverse side of the assessment in the section for "Summary of Assessment" was

marked with a checkmark: "Resident at risk for

depression, hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next

elopement, as evidenced by: dementia,

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		ER/SUPPLIER/CLIA ICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 323	to "Initiated." Intervere: "1. Personal and stairwell alarm Check every [hand word] hour." The anurse.  Admission Orders 12/8/10, signed but included, but were [Departure Alert Syplacement q [every "Above orders verif physician" with the space]/10."  An Elopement Risk indicated a check rithe following quest cognitively impaired skills?, Does the redementia, OBS [orgalized] Alzheimers, delusic depression, or schill ambulate independ of an assistive deviwander aimlessly? wandering behavioresident's past?" was a checkmark. resident been recell (within past 30 days situation?" where "checkmark. On the assessment in the Assessment" was rulesident at risk fowanders/pacing, [a	ventions se I safety ala s, and 4. From the vertien in blassessmen and Plan of assessmen and Plan of assessmen and Plan of assessmen and Plan of assessmen are to a second and plan of a stem of the vertien as Assessmen ark next to a sident have ganic brain ons, hallucing and brain ons, hallucing and brain and a sident have ganic brain ons, hallucing and brain and the plan and the plan and the plan and the sident and the plan and the sident and the plan and	rm devices, 2. Exit equent monitoring. ank space was the twas signed by a  Care dated by the physician, to, "Wanderguard ght] wrist - check enurse signed phone with is as: "12/[blank ent dated 12/10/10 or "Yes" answers to eresident decision making a diagnosis of syndrome] nations, anxiety, Does the resident or without the use Does the resident or without the use or routine tied to ibly" was written question, "Has the dor readmitted accepting of the was written was a de of the "Summary of a checkmark: t, as evidenced by:	F 3:	23		

#### PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 323 Continued From page 41 F 323 hx [history] of wandering aimlessly, ambulates independently. Next to "Appropriate interventions have been:" was a checkmark next to "reviewed." Interventions selected for review were: "4. Frequent monitoring. Check every [handwritten] hour, 5. Keep behavior logs, 8. Recreational activities, 9. Music, 13. Staff aware of wander risk, 14. Other: [handwritten] Wanderguard." The assessment was signed by the social worker. Documentation in the record failed to indicate the hourly monitoring of the resident was completed. During interview on 1/11/11 at 3:05 p.m., the Social Worker and Social Services/Activities Consultant discussed how the decision was made to use the Wanderquard system for this resident on 12/8/10. The Social Services/Activities Consultant indicated that on the day the resident moved into the facility, she was the Administrator at the facility and saw from her office window that the resident went out to his brother's truck as the brother was unloading the resident's belongings to bring into the facility. She indicated she felt the resident needed a Wanderguard at that time and requested it be used, and that the resident would be monitored for a quarter. She indicated she did not document the information.

period.

The admission Minimum Data Set assessment dated 12/16/10 indicated the resident did not have wandering behaviors during the assessment

A Care Plan Worksheet indicated a problem dated 12/8/10 for "Resident has been found to be at risk for elopement d/t [due to] depression, dementia, aimlessly wandering." The goal was, "Resident will not leave the facility unattended

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NAME OF P	ROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE		
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F 323	Continued From pathru [through] the neincluded, "Complete Use Redirection, diswhen resident attented Follow facility policy participation in active Ensure all basic neefor s/s [signs and symental health service Documentation faile was updated after 1 A Behavioral Contrasocial Worker date not limited to, relate "Wandering/Intrusive agreed to "2. Not out with my responsion other's rooms, office "I am willing to work them [behaviors]. The Problem solving resolve these issue Verbal reminders, 6 Resident teaching/ed A Care Plan Works Behavior Care Plan 12/14/10 and 1/6/11 presents with primadepression, bipolar [alcohol] abuse, OC disorder), and may	ext review.' e elopement straction are ptraction are ptraction are ptraction are ptraction and proced and proced to indicate a 12/16/10, and to behave to leave factsible party. e" The control of the staff with th	trisk assessment. Ind re-orientation bldg [building]. dures. Encourage lice and interest. een met. Observe of depression. ded or ordered." te the care plan  by the resident and included, but was lors, ent," and "I have cillity without signing outling without signing out	F	323			
	following moods an	d behaviors	s." The list of					

behaviors included, but was not limited to,

diffused daily thru [through] next review."

"...Wandering/Pacing within facility...Intruding into other's space." The Goal was "Episodes of moods and behaviors will be redirected and/or

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **203 SPARKS AVENUE** HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 43 F 323 Interventions included, but were not limited to, "...Bx [behavior contract] in place. Wanderquard bracelet - check placement & functioning q [every] shift." The Behavior Monthly Flow Record for December 2010 indicated the resident had behaviors including, but not limited to, continuous wandering on day shift on 12/18/10 and intruding into others' rooms and offices on day shift on 12/14, 12/18/10, 12/25/10, and 12/30/10. A psychiatric visit consult note dated 12/20/10 indicated, "Nsg [nursing] reports R [resident] having difficulty [symbol for with] adjustment -[symbol for not] sleeping at noc [night] - staying in lobby areas....' On 12/30/10 a physician's order was received for "May send to behavioral unit for evaluation & tx [treatment]." The History and Physical at the behavior center, dated 12/31/10 indicated, "History of Present Illness: ... More recently, he has been seen to be increasingly agitated and has been having behavioral problems. He has been stealing money and he has been intrusive and med [medication] seeking, and has been difficult to be redirected. He also smokes cigarettes and drinks diet coke constantly...."

1/5/11.

The resident was readmitted to the facility on

Documentation failed to indicate an Elopement Risk Assessment was completed upon the resident's return from the behavior center.

	TMENT OF HEALTH RS FOR MEDICARE						FORM	APPROVED
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F 323	Admission Orders a readmission include "Treatments: Wand [checkmark] placer level: Amb [ambulated] During interview on Director of Nursing need to check police Elopement Risk was from the behavior usame time, the Soc Services/Activities other and shook the monitoring of the real Elopement Risk As 12/10/10 were disconsided by Nurse hourly monitoring. I	and Plan of ed, but were lerguard to nent q shift" afory]."  1/11/11 at (DoN) indice to see if a sequired to init. During its Worker Consultant leir heads "Nesident indices sessments ussed.  p.m., docum Consultant of During intervallant indices in the edition of the edition o	a not limited to, rt. wrist and "Activity 3:05 p.m., the ated she would reassessment of upon readmission interview at this and Social ooked at each lo" when the hourly ated on the dated 12/8 and mentation was #1 related to the	F	323			
	Administrator's officentitled, "Specialized Observation for Wasexually Inappropridocuments indicated hourly from 12/8/10	ce. The doc and Monitoring Re ate Resident at 5:00 p.m igned and u d 12/13/10 in am deemed mbol for hot ehavior." C ant #1 prov Meeting Sun cated, "[nan ns, not sleer y team] rev	cuments were g Every Hour sidents and hts" The C was monitored h. until 12/13 at ndated notation on ndicated, no longer ur] checks d/t [due hn 1/12/11 at 3:45 ided copy of "Unit hmary" dated he of Resident C] - hoing wellup for lew hourly					

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PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 323 Continued From page 45 F 323 no] attempts @ departure elopement d/c [discontinue] please." Documentation failed to indicate the Elopement Risk Assessment and care plan were updated when the decision was made to discontinue the hourly monitoring. The Behavior Monthly Flow Record for January 2011 indicated on 1/5/11 one episode of "Non-compliance [symbol for with] smoking/smoking R/T Bx" on evening shift. On 1/6/11 indicated one episode each of "Intruding into other's rooms/offices" and "Rep [repetitive] questions" on day shift. The record included no nurse's notes after 1/6/11 at 3:00 p.m., which indicated, "...Resident up ambulating per self... No s/s [signs and symptoms] of distress noted."

all times. Procedures: 1. Identify residents at

FORM CMS-2567(02-99) Previous Versions Obsolete

updated at this time.

Social services notes for 1/6/11 indicated, "Spoke with resident's brother/POA about res's continued behavior even after returning from behavior unit. Brother stated res knows better, I'll come talk to him. I don't know what else to do with him. Discussed options including the locked down men's unit in [name of another town] that would possibly be more appropriate setting for resident. Brother stated he wanted to talk to resident, and see if he could get behaviors under control, and if not he would pursue considering another facility." Documentation failed to indicate care plans were

On 1/12/11 at 3:25 p.m., the facility's Elopement Risk Assessment Policy was provided by the Social Worker. Review of the policy indicated, "Policy: Assess residents for potential elopement. To assure that all residents are free from harm at

Event ID: 2WN411

Facility ID: 000110

If continuation sheet Page 46 of 49

	TMENT OF HEALTH						FORM	): 01/20/2011 1 APPROVED ): 0938-0391
STATEMEN <sup>*</sup>	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SL IDENTIFICATION	PPLIER/CLIA	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S	SURVEY
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F 323	risk for elopement l	y completing th	e elopement	F:	323	3		
	risk assessment up with significant char status. 2. Residen possible elopement interventions placed	on admission, on nges in mental/p ts who are ident will immediatel	uarterly and esychosocial dified for y have					
	B. During Initial To between 9:50 a.m. door alarms were o Supervisor and Nur present intermittent	and 11:45 a.m., bserved. The N se Consultant#	various facility laintenance 2 were					
	described various a floors: the ground f lot; the first floor, wi	larms. The faci loor, leading to	lity has three a back parking					1
	second floor with earn front door to the exit doors into the f	kit through the face street. The first acility's enclosed	acility lounge at floor has two d outdoor					
	courtyard. The sec door from the 2-Eas exit door to the outd	st and 2-West had been smoking pa	allways, an itio, and a					
	delivery door. The included a Wanders System) at the facili	guard (Departur ty's second floo	e Alert r front					
	entrance, at elevators and at the ground fluors with Wanders	oor back entran Juards are appr	ce. When the pached by a					
	resident wearing a value of the Wanderguard statement alarms or hardwire	s which were no ystem had batte	ot connected to					
	,							
	During observation patio gate alarm lea checked for function Supervisor. The ala Maintenance Super	ding to the stree ning by the Main arm did not sour	et was tenance nd when the					
	interview at this time indicated, "Someon	e, the Maintenar	nce Supervisor					

PRINTED: 01/20/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 155203 01/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 Continued From page 47 F 323 indicated he "had to get back to the beginning of the cycle" to set the alarm to function. The Maintenance Supervisor indicated the door alarm was not battery operated but hardwired into the electrical circuit. During review of the Elopement Binder on the facility's Transitional Care Unit on 1/11/11 at 10:50 a.m., 16 residents from the facility were listed as "Residents at Risk for Elopement." During interview at this time, Nurse Consultant #2 indicated the Elopement Binder had been updated since a resident's elopement on 1/8/11. and all residents at risk for elopement were being checked every 15 minutes. During observation on 1/11/11 at 10:40 a.m., the door alarm from the facility's secured unit, leading from the nurse's station into the facility's courtyard used by residents for supervised smoking, failed to alarm when opened by the Maintenance Supervisor. During interview at this time, the Maintenance Supervisor indicated the alarm needed a new battery. He indicated he had been busy with snow removal during the morning and had not done alarm safety checks. During observation on 1/11/11 at 12:45 p.m., the door alarm at the end of the 2-West hall was checked by Nurse Consultant #2. The door failed to alarm when the Consultant opened it. The Consultant closed the door and opened it a

second time, and the alarm did not sound. The Consultant opened the door a third time, and the alarm sounded. The Maintenance Supervisor approached, and the Consultant indicated to him

that the door had a "glitch" in its function.

During interview on 1/11/11 at 1:30 p.m., the

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVID	ER/SUPPLIER/CLIA ICATION NUMBER:	(X2) MU A. BUILI	DITIPLE CONSTRUCTION DING		(X3) DATE SI COMPLE	URVEY ETED
			155203	B. WINC	G		1	C <b>2/2011</b>
	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
HILLCRE	ST CENTRE FOR HE	ALTH AND	REHABILITATION		203 SPARKS AVENUE JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PR	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOU E APPR	JLD BF	(X5) COMPLETION DATE
F 323	Continued From pa Consultant for Socia after a resident's ele facility had ordered doors not connecte She indicated the fa current alarms. Sh be installed immedi This federal tag rela 3.1-45(a)(1) 3.1-45(a)(2)	al Services opement, onew door and to the Wallity had come indicated ately upon	n 1/10/11, the alarms for all facility anderguard system. oncerns with the the alarms would arrival at the facility	F 32	23			